MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION INFORMATION FOR A PREVIOUSLY LICENSED CALIFORNIA PHYSICIAN

MINIMUM REQUIREMENTS TO REAPPLY FOR LICENSURE

- In accordance with Section 2428 of the California Business and Professions Code, a physician whose California Physician's and Surgeon's license expired five or more years ago must reapply for licensure. If you voluntarily canceled your license, you must reapply regardless of the time period.
- Although Section 2428 allows you to undertake a re-application process that is significantly streamlined, you must meet all of the requirements as if you were applying for licensure for the first time.
- You must have completed at least two years of ACGME/RCPSC accredited postgraduate training or have completed one year of approved training and be certified by a specialty board approved by the American Board of Medical Specialties (ABMS).

GENERAL INFORMATION

- As an applicant, you personally are responsible for all information disclosed on your Application, Forms L1A-L1F, including any responses that may have been completed on your behalf by others. An application may be denied based upon omission, falsification or misrepresentation of any item or response on the application or any attachment. The Medical Board of California considers violations of an ethical nature to be a serious breach of professional conduct.
- **Processing Times:** Application materials are processed in the date order in which the application is received in this office. All application forms and supporting materials are stamped with the date and time received in the office. Generally, you should anticipate receiving written correspondence confirming the status of the application for a medical license within 60 days of submission of the application.
- **Grounds for Denial**: Each applicant's credentials for licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty, unprofessional conduct, conviction of a crime, discipline of another state license or inability to practice medicine safely.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

GENERAL INFORMATION

- **Fingerprints**: Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form that may be obtained from our Web site. Please refer to the following Web site for a listing of Live Scan facilities in California: http://ag.ca.gov/fingerprints/publications/contact.php

  Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees. All personal data must be completed on the fingerprint cards.

  Please be aware that if you have ever suffered a conviction, the record of the conviction will be reported to the Board as a result of your fingerprint inquiry. *Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Physician's and Surgeon's License.*

- **Convictions**: Note that convictions adjudicated in juvenile courts or convictions two years or older under Health and Safety Code sections 11357(b), (c), (d), (e) or section 11360(b) need not be reported. Convictions expunged or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. The Board receives information regarding convictions that have been expunged.

- **Due Diligence**: Pursuant to Section 1306 of Title 16 California Code of Regulations, an application shall be deemed abandoned if an applicant fails to complete the application process within 365 days from the date of written notification from the Board of the documents needed to complete the application.

APPLICATION INFORMATION

Listed below are the minimum application and supporting materials required to reapply for your license. This list is not all-inclusive as additional items may be necessary based on responses provided on your *Application* or information obtained from other entities. Please refer to the *Checklist for a Previously Licensed California Physician* and our Web site for further detailed information regarding each requirement.

Upon receipt of your application and fees, we will retrieve your previously imaged licensing record and determine what documents may be used to meet the current requirements. In the event our imaged records do not contain all of the documents that are currently required, you may be requested to submit additional documents.

- Application for Physician's and Surgeon's License, Forms L1A-L1F
- Copy of Live Scan Request Form (CA resident) or Two Fingerprint Cards (Outside CA)
- Application fees of $491.00 or copy of online payment receipt
- Current Curriculum Vitae (CV)
- Explanation to Question #__ Form (if applicable)
- Return original California Wall Certificate
- Official license verification(s)
- Initial licensing fee of $808.00

MEDICAL BOARD OF CALIFORNIA
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Checklist for a Previously Licensed California Physician
(Do Not Submit - Keep For Your Records)

Application, Fees, and Fingerprints			
☐	**Application Fee**	A minimum of $491.00 is required to submit an application to reapply for licensure. Refer to the *Fee Schedule* for details.	Notes/Date Sent:
☐	**Initial License Fee $808.00**	Refer to the *Fee Schedule* for details.	Notes/Date Sent:
☐	**Application For Physician's and Surgeon's License, Forms L1A-L1F**	Complete all fields, answer all questions, and have the application notarized.	Notes/Date Sent:
☐	**Fingerprints:** **Live Scan Form (CA Only)** ***or*** **Two (2) Fingerprint Cards**	Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. A copy of the completed *Request for Live Scan Service* form must be submitted with your application. The form may be obtained from the Board's Web site. Applicants residing outside of California may submit two completed fingerprint cards or visit a California Live Scan facility. *Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees.* All personal data must be completed on the fingerprint cards.	Notes/Date Sent:
Verification of Other State Medical License(s)			
☐	**License Verification**	License verification is required from <u>each</u> state or Canadian province in which you hold or have held a medical license. Verification of temporary, training, or provisional license(s) are <u>not</u> required. *<u>Request that the official license verification be mailed directly from the licensing authority to our Board.</u>*	Notes/Date Requested:
Other Items			
☐	**Original California Wall Certificate or Notarized Statement**	Return your original California wall certificate. If it has been lost or destroyed, you must submit a notarized statement indicating the reason you are unable to return the original.	Notes/Date Sent:
☐	**Birth Month Licensure Request**	Complete the Birth Month Licensure Request form and mail it in with your Application.	Notes/Date Sent:
☐	**Curriculum Vitae (CV)**	Please submit a signed and dated current CV with your Application.	Notes/Date Sent:
☐	**Explanation to Application Question #____** *(if applicable)*	This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use a separate page for each positive response. The form may be obtained from our Web site.	Notes/Date Sent:

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MEDICAL BOARD OF CALIFORNIA
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FEE SCHEDULE

Application for Physician's and Surgeon's License
or
Postgraduate Training Authorization Letter (PTAL)

Part 1: Application Fee			
The application fee includes a required fingerprint processing fee. Please note, the application will not be reviewed until the required application fee is received.			
Total Non-Refundable Application Fee	**Required** →		**$ 491.00**
Part 2: License Fee			
License fees are required prior to issuance of your medical license. To reduce delays in issuing a license, you may submit the application and license fees together. **Initial License Fee ($808.00) or Reduced Initial License Fee ($416.50)** – If you currently are enrolled in an ACGME/RCPSC accredited training program, you may be eligible for the reduced initial licensing fee. To verify your enrollment, you will need to submit a Certificate of Current Postgraduate Training, Form L4. **NOTE:** PTAL applicants are not required to submit the initial license fees until all licensing requirements have been met.			
Initial License Fee **or** **Reduced Initial License Fee**	**Required Prior to Licensure**	**$808.00 or $416.50**	**$**
Part 3: Voluntary Fee			
You may contribute $25 to provide training for family physicians and other primary care providers who will serve medically underserved rural and inner city Californians, refugees, the frail elderly and people with AIDS. This program was established as a result of legislation authored by the late Dr. William Filante and is supported by the California Medical Association, the California Academy of Family Physicians, and other leading health care organizations. Dr. Filante's bill authorized this State's Office of Statewide Health Planning and Development (OSHPD) to accept contributions from certain foundations, health maintenance organizations, health insurers and entities to augment these primary care training programs, which are located in hospitals throughout California.			
Family Physician Training Fee	**Voluntary**	**$25.00 (minimum)**	**$**
Part 4: Total Amount			**$**

Certified Check, Cashier's Check, Money Order, or Personal Check made payable to:
MEDICAL BOARD OF CALIFORNIA

or

At time of initial application, you may make a one-time online payment at: http://www.dca.ca.gov/proflic/medicalbd.shtml

07A-100 Revised 8/2013

MEDICAL BOARD OF CALIFORNIA
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APPLICATION

(Please Check All That Apply)

☐ **Physician's and Surgeon's License**
☐ **Postgraduate Training Authorization Letter (PTAL)**
☐ **Update Application: ATS #**_____
☐ **Limited Practice License**

(Please Check One)

☐ **U.S. or Canadian Medical School Graduate**
☐ **International Medical School Graduate**

Type or Print Legibly

PERSONAL INFORMATION

				MBC Use Only
1. Legal Name	Last	First	Middle	
2. Other Names/Alias				
3. United States Social Security Number		**4. Gender**		
		☐ Male ☐ Female		
5. Date of Birth (mm/dd/yyyy)		**6. Place of Birth** (City, State/Country)		
7. Public/Mailing Address **If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.**	Mailing Address *(30 characters maximum per line, including spaces)*			
	Mailing Address continued *(30 characters maximum per line, including spaces)*			
	City	State/Province	Zip/Postal Code / Country	Personal Information
8. Telephone Numbers	Home #	Work #	Cell #	❑
9. E-mail Address				

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?	☐ Yes ☐ No	❑
11. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	☐ Yes ☐ No	Prev License ❑

EXAMINATIONS

12. Have you ever been found to have engaged in irregular behavior during an examination?	☐ Yes ☐ No	Exams ❑
13. Have you ever been subject to an investigation by an examination entity?	☐ Yes ☐ No	❑
14. Are you certified by the Educational Commission for Foreign Medical Graduates? If yes, please provide the Certificate Issue Date: _____	☐ Yes ☐ No	❑

15. List all of the following examinations you have taken: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**
(Use the *Addendum to Question #15 Form* if additional space is needed)

Examination	Date (mm/yyyy)	Result (Pass/Fail)	
			❑
			❑
			❑
			❑
			❑

Cashiering Use Only	School Code	
		L1A

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MEDICAL EDUCATION

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NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). To view the Board's list, please refer to our Web site at: http://www.mbc.ca.gov/applicant/schools_recognized.html.

16. List each medical school that you have attended.

Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)		L2 ❑ Trans ❑ School Code
		Start		
		End		
		Start		❑ ❑
		End		
		Start		❑ ❑
		End		

17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	Diploma ❑

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Unusual Circumstances

18. Did you ever take a leave of absence during medical school?	☐ Yes ☐ No	❑
19. Were you ever placed on probation?	☐ Yes ☐ No	❑
20. Were you ever disciplined or placed under investigation?	☐ Yes ☐ No	❑
21. Were any negative reports ever filed by your instructors?	☐ Yes ☐ No	❑
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	☐ Yes ☐ No	❑

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

Postgraduate Training

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? ***List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.***
(Use the *Addendum to Question #23 Form* if additional space is needed)

(*If NO please skip to question # 33*) ☐ Yes ☐ No ❑

Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy)		
			Start		❑
			End		
			Start		❑
			End		
			Start		❑
			End		
			Start		❑
			End		

APPLICANT: (Print Name)

DATE OF BIRTH: (mm/dd/yyyy)

L1B

A "yes" response to questions 18-22 requires a signed and dated written explanation.

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

MBC Use Only

24. Have you ever received partial or no credit for a postgraduate training program?	☐ Yes ☐ No	❑
25. Have you ever taken a leave of absence or break from your training?	☐ Yes ☐ No	❑
26. Have you ever been terminated, dismissed or expelled from a program?	☐ Yes ☐ No	❑
27. Have you ever resigned from a program?	☐ Yes ☐ No	❑
28. Were you ever placed on probation for any reason?	☐ Yes ☐ No	❑
29. Were you ever disciplined or placed under investigation?	☐ Yes ☐ No	❑
30. Were any incident reports ever filed by instructors?	☐ Yes ☐ No	❑
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes ☐ No	❑
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐ Yes ☐ No	❑

MEDICAL LICENSE

33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.*** (Use the *Addendum to Question #33 Form* if additional space is needed)	☐ Yes ☐ No	License ❑

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)	
					❑
					❑
					❑
					❑
					❑

ABMS CERTIFICATION

34. Are you currently certified by a Member Board of the American Board of Medical Specialties?	☐ Yes ☐ No	ABMS ❑

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked?	☐ Yes ☐ No	❑
36. Is there any action currently pending against you?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	DATE OF BIRTH: (mm/dd/yyyy)	L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

DEA CERTIFICATION

MBC Use Only

		MBC Use Only
37. Are you currently registered with the Drug Enforcement Agency (DEA)?	☐ Yes ☐ No	DEA ❑

DEA Number	State of Issue	Expiration Date (mm/yyyy)	
			❑
			❑

38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	☐ Yes ☐ No	❑
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	☐ Yes ☐ No	❑

MALPRACTICE HISTORY

		Malpractice History
40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	☐ Yes ☐ No	❑
41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	☐ Yes ☐ No	❑

DISCIPLINARY HISTORY

Disciplinary History

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or foreign country.

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	☐ Yes ☐ No	❑
43. Have you ever been denied a license to practice medicine?	☐ Yes ☐ No	❑
44. Is any denial pending against you?	☐ Yes ☐ No	❑
45. Have you ever had any license to practice medicine subjected to any disciplinary action?	☐ Yes ☐ No	❑
46. Is any disciplinary action pending against any of your licenses to practice medicine?	☐ Yes ☐ No	❑
47. Have you ever surrendered a license to practice medicine?	☐ Yes ☐ No	❑
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	☐ Yes ☐ No	❑
49. Have you ever had any license to practice medicine subjected to any action including, *but not limited to*, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	☐ Yes ☐ No	❑
50. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	☐ Yes ☐ No	❑
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	☐ Yes ☐ No	❑
52. Is any disciplinary action pending against your hospital or staff privileges?	☐ Yes ☐ No	❑
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	☐ Yes ☐ No	❑
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	DATE OF BIRTH: (mm/dd/yyyy)	L1D

A "yes" response to questions 38-54 requires a signed and dated written explanation.

CRIMINAL RECORD HISTORY

MBC Use Only

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction disclosed, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

Criminal History

55. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	☐ Yes ☐ No	❑
56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	☐ Yes ☐ No	❑
57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	☐ Yes ☐ No	❑
58. Are you a registered sex offender?	☐ Yes ☐ No	❑

PRACTICE IMPAIRMENT OR LIMITATIONS

If you give an affirmative answer to any of the questions below, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a Limited Practice License may be available. Please refer to the *Application Information for a Limited Practice License* for further information.

Limitations

59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	☐ Yes ☐ No	❑
60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	☐ Yes ☐ No	❑
61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❑
62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❑
63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❑
64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	**DATE OF BIRTH:** (mm/dd/yyyy)	**L1E**

A "yes" response to questions 55-64 requires a signed and dated written explanation.

PHOTOGRAPH

MBC Use Only

Photograph

Affix a 2" X 2" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only

Altered Photographs are NOT Acceptable

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

Photograph ❑

DECLARATION

Applicant Name & DOB ❑

The applicant, _____, _____,
Please print full name (First, Middle, Last) **Date of Birth (mm/dd/yyyy)**
being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ❑

SIGNATURE:_____**DATE:**_____

NOTARY SECTION

Applicant Signature ❑

SIGNATURE OF APPLICANT: _____
(**DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY** – Please sign full name)

State of _____

County of _____

Applicant Name & Notary Date ❑

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by, _____ proved to me on the basis of satisfactory evidence
(**Print applicant's name**)

to be the person who appeared before me.

Notary Signature & Seal ❑

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L1F

MEDICAL BOARD OF CALIFORNIA
Licensing Program

EXPLANATION TO APPLICATION QUESTION #_____

This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use as many forms as necessary to provide a detailed explanation. A separate form is to be used for each question.

Type or Print Legibly **APPLICANT INFORMATION**

NAME: **Last** **First** **Middle**

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

NARRATIVE EXPLANATION

SIGNATURE: _____ DATE: _____

Applicant's signature and date are required.

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BIRTH MONTH LICENSURE REQUEST

California licensing regulations specify that a license expires at 12 midnight on the last day of the birth month of the licensee during the second year of a two year term. If you are licensed in your birth month, your initial license will be valid for a full 24-month term. If you are licensed in a month other than your birth month, the term of your *initial license* will be less than 24-months.

Please indicate your preference by checking one of the options listed below:

☐	**I would like to wait until my birth month of _____ to be licensed.**
☐	**I would like to be licensed as soon as my application is processed. I understand and acknowledge my *initial license* will be valid for less than a 24-month term.**

Printed Name of Applicant: _____
(As it appears on Form L1A)

ATS#: _____
(If Known)

Date of Birth: _____
(mm/dd/yyyy)

Signature of Applicant: _____ Date: _____

Please return the form using one of the following methods:

1. Submit the completed form with your initial application.
2. Fax the completed form to the Board at (916) 263-2487.
3. Mail the completed form to the address listed below.

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